STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	C 11/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from October 29, 2018 through November 5, 2018. The facility census the first day of the survey was 115 (one hundred fifteen). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 29, 2018 through November 5, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115. The survey sample totaled 53. Abbreviations and Definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; OT - Occupational Therapist; PT - Physical Therapy / Physical Therapist; QA - Quality Assurance; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/10/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

RNM-restorative nurse manager;
SW - Social Worker;
UM - Unit Manager;
WCN-wound care nurse;
ADL - Activities of Daily Living;
APIC-association for professionals in infection control;
BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15. [0-7= severe impairment; 8-12=moderate impairment; 13-15=cognitively intact];
Coccyx - a small triangular bone at the base of the spinal column;
cognitive- thinking, memory;
Delusion - false belief that is thought to be true;
Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation or loss of mental functions such as memory and reasoning and it interferes with a persons daily functioning;
e.g.-and so forth;
Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support;
Foley catheter-tube that drains urine from the bladder;
Honey Thickened - consistency is thick, like honey;
i.e.-that is;
IDT - Interdisciplinary Team;
ischium-boney areas on each buttock;
Minimum Data Set (MDS) - standardized assessment forms used in nursing homes;
ml-milliliters-unit of liquid volume;

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F 000	Continued From page 2 Mobility- the ability to move or be moved freely and easily; Nectar Thickened - is the least thickened, meaning that it is closer in consistency to a thin liquid such as water; Nepro-liquid feeding supplement; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; Peg tube-tube inserted in the stomach for feeding; Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Pressure Ulcer Stage 4 - open sore so deep that muscle, tendon, or bone can be seen/felt; Psychotic -suffering psychosis; psychosis-loss of contact/touch with reality; Total dependence- full staff performance of an activity; Tracheostomy - an opening in the throat made to assist with breathing; Vegetative state-consciousness has been affected by brain damage.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F 565		1/3/19

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F 565	Continued From page 3 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and review of resident council meeting minutes, it was determined that the facility failed to act promptly upon resident grievances or to provide rationale for failure to act upon the grievances. Findings include: March - October 2018: Review of the Resident Council meeting minutes revealed no evidence that the following repeat concerns were addressed or that the residents were provided any follow up information on the status of their concerns: 1. Respect for residents (May and April)	F 565	Individual/Resident Impacted The facility failed to promptly communicate the action taken in response to resident grievances, or to provide rationale for the manner in which grievances were addressed. The Grievance Officer immediately corrected this deficient practice by changing the facility s documentation process detailing resident grievances, as well as the manner in which the facility s response will be communicated to the residents. The facility will institute a formal documentation approach of the resident	

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F 565	Continued From page 4 2. Wi-fi at nursing stations and in auditorium (October and September) 3. Candee 5 Catwalk: still water in Catwalk and sand bags an eyesore (October and September) 4. Candee 1 Porch residents requesting freestanding ashtrays not the ones that sit on tables and need more ashtrays (May, April and March) 5. Candee2 ventilation system too loud (May, April and March) 6. Candee2 3-11 staff do not make coffee for residents (October, September, May, April and March) 11/5/18 4:00 PM - Interview with E1 (NHA): E1 states that he spoke with the facility treatment team and it was determined that these issues have been addressed; however, it was not addressed in the resident council minutes. The facility will come up with a more formal approach to document the resident concerns as they are brought to the staffs' attention at the resident council meetings, and that the assigned staff will also be sure all residents have been made aware of the results of the requested investigations and concerns. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 565	concerns and grievances as they are brought to the facility s attention at the Resident Council meetings. With the continued permission of the facility s Resident Council President, the Hospital Social Services Administrator II will be responsible for accurately documenting and communicating the results of the requested investigations and concerns shared by residents at the Resident Council meetings. Identification of other residents with the potential to be affected All residents in the facility have the potential to be affected by this deficient practice of the facility failing to promptly communicate the action taken in response to resident concerns and grievances, or to provide rationale for the manner in which the grievances were addressed. All outstanding resident concerns and grievances that were brought to our attention were immediately addressed, and discussed at the subsequent Resident Council meeting on 11/13/18. The Resident Council President provides the Hospital Social Services Administrator II with a list of all of the facility staff that they wished to have invited to the Council meeting so that their concerns could be heard and addressed by the appropriate individuals. Invitations are sent out to those individuals. After the Council meeting takes place, the Hospital Social Services Administrator II will obtain permission from the resident council president to compile the council meeting minutes using the new documentation	

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F 565	Continued From page 5	F 565	format and after the approval of the Resident s Council President the minutes will then be distributed to the residents. System Changes The root cause of this deficient practice was lack of an established process of addressing resident concerns and grievances and an inadequate documentation method that would clearly explain the facility s response to those concerns and grievances. The facility will institute a formal documentation approach to record resident concerns and grievances as they are brought to our attention at the Resident Council meetings. For urgent matters brought to our attention, the Hospital Social Services Administrator II will immediately address and communicate the results of the investigations and concerns with the resident(s) involved. With the continued permission of the Resident Council President, the Hospital Social Services Administrator II will document the responses to the requested investigations and concerns that are presented at the Council meeting in the meeting minutes. The meeting minutes will be approved by the Council President and will be distributed to all residents. A copy of the Resident Council meeting minutes (Attachment 1) will also be added into the resident monthly newsletters (The Chatter) to ensure that all residents are informed of the results of the requested investigations and concerns. A wild card memorandum has been sent to all department managers informing them of	

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F 565	Continued From page 6	F 565	our new process. The Hospital Social Services Administrator II will be responsible for ensuring that all department managers maintain compliance with this new process. Success Evaluation The Hospital Social Services Administrator II will review all Resident Council meeting minutes with the Resident Council President monthly for four consecutive months to verify that all reported concerns presented at Council meetings are adequately addressed. Once we have assured that the meeting minutes are approved by the Council President, are distributed to all residents, and are included in the resident monthly newsletters (The Chatter), the Hospital Social Services Administrator II or designee will meet with 25 percent of all interviewable residents to ensure that they are aware of the resolutions to their reported concerns. If we determine that we have not achieved sustained compliance after four consecutive months, then we will meet with the Resident Council President to review our documentation process and make any necessary changes to ensure that the residents are adequately informed of resolutions to their reported concerns. A monthly summary report will be provided to the Nursing Home Administrator (NHA) and Quality Assurance Department. The results will be reviewed at the monthly QAPI Committee meetings and each Quarterly QAPI Steering Committee meeting until 100 percent compliance is	

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F 565	Continued From page 7	F 565	met. If the results indicate that the facility has achieved 100 percent compliance after six consecutive months, the facility will conclude that they have successfully addressed this deficient practice.	
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or	F 574		1/3/19

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F 574	Continued From page 8 federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to post in areas accessible to all residents and visitors the names,	F 574	Individual/Resident Impacted The facility failed to post, in areas accessible to all residents and visitors, the	

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F 574	Continued From page 9 addresses, and telephone numbers of all pertinent State client advocacy groups such as the State Long-Term Care Ombudsman program, a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. Findings include: 11/1/18 2:00 PM: During the Resident Council Meeting, in response to the question "Do residents know where the Ombudsman's contact information is posted?", 13 (R109, R71, R53, R67, R35, R20, R82, R74, R98, R2, R75, R37 and R9) residents attending the meeting answered "no." 11/1/18 10:00 AM, a tour of all five of the facility's units and the Candee Building lobby revealed that the postings of contact information for the State Survey Agency, posting of a statement regarding the filing of a complaint with the State Survey Agency, posting with information informing residents how to file a complaint with the State Agency, and posting with contact information for the Long Term Care Ombudsman were in too small a font size to be easily read by residents. On the Candee 200 and 500 units some required information was covered with other postings such as information on flu shots. The facility failed to provide information on how to contact the State Agency, how to formally complain to the State Agency and the Ombudsman's contact information, in areas accessible to all residents, visitors and staff. Findings reviewed with E1 (NHA), E2 (DON), and	F 574	contact information (names, addresses, and telephone numbers) of all pertinent State client advocacy groups, such as State Long-Term Care Ombudsman program, as well as a statement that the resident may file a complaint with the State survey and certification agency concerning: 1) resident abuse, neglect, and misappropriation of resident property in the facility; and 2) non-compliance with the advance directive requirements. The facility immediately corrected this deficient practice by posting, throughout the facility, information regarding ways to contact the independent entities with whom grievances may be filed. The postings also informed residents that a complaint may be filed in writing and/or anonymously with the State survey and certification agency. The Grievance Officer will be responsible for ensuring that the postings remain accessible to all residents and visitors at all times. Identification of other residents with the potential to be affected All residents in the facility have the potential to be affected by this deficient practice for failing to post pertinent contact information and the process of reporting complaints anonymously and/or in writing, in a location accessible to all residents and visitors. All pertinent information related to relevant agency contact information and the grievance process was posted throughout the facility and made accessible to all residents and visitors as of 11/8/18. (Attachment 2)	

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F 574	Continued From page 10 E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 574	System Changes The root cause of this deficient practice was lack of established procedures for posting the required notices and contact information for all pertinent State client advocacy groups in areas accessible to all residents and visitors. Agency contact information and the grievance process was updated and posted throughout the facility. The Grievance Officer or designee will communicate orally and in writing the grievance/complaint process and how to access pertinent contact information to the residents at the monthly Resident Council meetings. A copy of the posting will also be added into the resident monthly newsletters (The Chatter). Success Evaluation The Hospital Social Services Administrator II or designee will review all resident monthly newsletters (The Chatter) to ensure that the following information is accurately documented, and communicated, to all residents: 1) Contact information for all pertinent State client advocacy groups, 2) Instructions for residents about how to file a complaint with the State survey and certification agency, which can be done in writing and/or anonymously. The Continuous Quality Improvement Nurse (CQI RN III) will conduct random monthly observations to ensure that the postings remain accessible to residents and visitors throughout the facility for 6 consecutive months. The results will be reviewed at the monthly QAPI Committee and Quarterly QAPI Steering Committee	

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F 574	Continued From page 11	F 574	meetings. If it is determined that 100 percent compliance is achieved for 6 consecutive months then we will conclude that we have successfully addressed this cited deficient practice.	
F 577 SS=F	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and resident council meeting it was determined that the facility failed to ensure the survey results were posted in	F 577	Individual/Resident Impacted The facility failed to ensure the survey results were posted in a place accessible	1/3/19

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F 577	Continued From page 12 a place accessible to residents, family, and legal representatives to review without having to ask the facility for the results. Findings include: 11/1/18 2:00 PM - Resident council meeting: 13 Residents (R109, R71, R53, R67, R35, R20, R82, R74, R98, R2, R75, R37 and R9) attended the meeting. When asked, "Without having to ask, are the results of the State inspection available to read?" They answered they did not know. 11/2/18 1:15 PM - Observation in Candee Building main lobby: An unlabeled notebook was found on a table that contained the 2017 Annual Survey results only. No sign to indicate that the State inspection results were available was found. 11/2/18 3:15 PM - Interview: E1 (NHA) was notified of the above findings, that the past three years of survey results must be accessible to residents without having to ask the facility and that no sign was found indicating where the survey results were. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 577	to residents, family, and legal representatives to review without having to ask the facility for the results. The facility immediately corrected this deficient practice by posting the last three years of survey results in designated locations throughout the facility. The Grievance Officer will be responsible for ensuring that the survey results remain accessible to all residents and visitors in the designated locations. Identification of other residents with the potential to be affected All residents in the facility have the potential to be affected by this deficient practice of not posting survey results in a place accessible to residents, family, and legal representatives. All pertinent information was made accessible to all residents and visitors in designated locations throughout the facility as of 11/8/18. (Attachment 3) System Changes The root cause of this deficient practice was lack of established procedures for posting the survey results in areas accessible to all residents and visitors. The facility posted the last three years of survey results, with signs indicating the locations and process by which residents and visitors can review and/or obtain copies of the survey results. The Grievance Officer/Social Services Administrator II or designee will communicate this information to all residents at each monthly Resident Council meeting. This information will also	

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F 577	Continued From page 13	F 577	be communicated through the monthly resident newsletters (The Chatter). (Attachment 4) Success Evaluation The Hospital Social Services Administrator II will review all resident monthly newsletters (The Chatter) to ensure that the locations of the survey results and process by which residents and visitors can review and/or obtain copies of the survey results are accurately documented and communicated to the residents. The Continuous Quality Improvement Nurse (CQI RN III) will conduct random monthly observations to ensure that the survey results remain accessible to all residents and visitors in the designated locations for 6 consecutive months. The results will be reviewed at the monthly QAPI Committee and Quarterly QAPI Steering Committee meetings. If it is determined that 100 percent compliance is achieved for 6 consecutive months then we will conclude that we have successfully addressed the cited deficient practice.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		1/3/19

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F 584	Continued From page 14 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain a clean, comfortable and homelike environment. In one room (room 111) the facility failed to maintain mechanical and electrical equipment in safe operating condition. The facility failed to maintain	F 584	Item 1 Sink Light Pull Cord and Light Fixture Cover Individual/Resident Impacted The facility failed to maintain a clean, comfortable and homelike environment in room 111, by not maintaining mechanical	

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F 584	Continued From page 15 a quiet comfortable environment on Candee 2. Findings included: 1. 10/29/18 at approximately 9:48 AM - An observation of room 111's sink area, revealed the over the sink light pull cord was missing. In addition, the light fixture cover was missing with electrical wiring exposed. 10/29/18 at approximately 9:50 AM - An interview with assigned aide, E11 (CNA), revealed, both of the residents in the room, R54 and R66, were independent with ambulation and utilized the sink. 10/29/18 at approximately 10:04 AM - An interview with E7 (RN, UM) confirmed the findings and E7 verbalized that maintenance will be contacted. 2. The following was observed on Candee 2: Observations on Candee 2: A loud disturbing noise was heard each time the medication room door slammed shut: -11/1/18 from 9:15 AM to 10:00 AM the door slammed loudly five times. -11/1/18 from 10:55 AM to 12:45 the door slammed loudly nine times. -11/2/18 from 9:30 AM to 10:20 AM the door slammed loudly three times. 11/2/18 12:15 PM - Interview: E1 (NHA) was notified of the disturbing noise from the medication room door slamming and said he will have maintenance staff fix it. 11/5/18 9:00 AM - Interview with R46 revealed the door slams shut so loud that it was startling and frequently wakes her up at night.	F 584	and electrical equipment in safe operating condition. Observation of room 111 revealed that the sink light pull cord and light fixture cover were missing leaving electrical wiring exposed. A corrective action was immediately taken by initiating a work order number (19-122202) in the Asset Inventory Management (AIM) work order system to resolve the concern. The Division of Management Services (DMS) Facility Operations completed the work order on October 29, 2018. (Attachment 5) Identification of other residents with the potential to be affected All residents have the potential to be affected by the deficient practice of the facility failing to promptly maintain an environment that is clean, comfortable, and homelike. The Division of Management Services (DMS) Facility Operations staff immediately checked all residential areas for similar light fixtures, pull cords and electrical wires to ensure that they were operable and safe for resident use. System Changes The root cause of the deficient practice was a lack of established system and procedures for conducting environmental inspections. An environmental checklist was developed for conducting environmental inspections. The Risk Manager/Safety Officer or designee will conduct monthly environmental inspections of all residential, common areas and hallways (Attachment 6).	

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F 584	Continued From page 16 11/5/18 9:35 AM - Interview with R82 revealed the door slams shut so loud that it was startling and frequently wakes her up at night. 3. The following was observed on Candee 2: 11/5/18 at 9:47 AM - It was observed that on Candee 2 room 255 a dirty linen room door squeaks when open and closed and closes loudly. 11/05/18 9:54 AM - During an interview with E24 (LPN) it was confirmed they would have maintenance come and take a look at the door for the squeaking and closing noises. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 584	Additionally, the DMS Facility Operations staff will continue to perform random environmental rounds and will conduct quarterly inspections of all resident care areas (Attachment 7). All environmental findings will be promptly addressed and communicated to staff and residents affected by actions taken to resolve any deficient areas ensuring that the residents needs are met. Communication will also be provided to all residents on the new grievance/complaint process so that they can report any environmental concerns. The DMS and Nursing staff will promptly document and track all work orders submitted through the AIM work order system. Success Evaluation The Risk Manager/Safety Officer or designee will verify that all submitted work orders that impact residents are completed promptly and accurately weekly for eight consecutive weeks. Any work orders that were not completed will be communicated to the Nursing Home Administrator (NHA) for follow-up and to ensure timely completion. To ensure completeness and sustainability, an audit of 50% of the monthly work orders will be completed for three consecutive months. All audit results will be submitted to the Nursing Home Administrator (NHA) and Quality Assurance Department and the results will be reviewed at the monthly QAPI Committee meetings. If 100 percent compliance is not achieved, then the Risk Manager/Safety Officer or designee and NHA will meet with the DMS Facility	

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F 584	Continued From page 17	F 584	Operations staff to determine the plan of action moving forward. If it is determined that 100 percent compliance is achieved, then we will conclude that we have successfully addressed this cited deficient practice. Item 2 Loud Disturbing Noise Medication Room Door Individual/Resident Impacted The facility failed to maintain a clean, comfortable and home like environment as observed by R46 and R82s report of a loud disturbing noise heard when closing the Candee 200 medication room door. A corrective action was immediately taken to address the deficient practice by initiating a work order number 19-122707 (Attachment 8) in the AIM work order system to resolve the loud disturbing noise on Candee 200 nursing unit. The DMS Facility Operations staff completed the work order that addressed the cited findings on November 02, 2018. The Nursing Home Administrator (NHA) and Charge Nurse on Candee 200 interviewed R46 and R82. Both R46 and R82 reported that the noise issue was addressed and resolved. Identification of other residents with the potential to be affected All residents have the potential to be affected by the deficient practice of the facility failing to maintain a quiet homelike and comfortable environment. The DMS Facility Operations staff immediately checked all residential areas for similar door closures to ensure that they were	

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F 584	Continued From page 18	F 584	properly operable and safe for use. System Changes The root cause of the deficient practice was a lack of established system and procedures for conducting environmental inspections. An environmental checklist was developed for conducting environmental inspections specific to door closure in resident care areas. The Risk Manager/Safety Officer or designee will conduct monthly environmental inspections of all doors in resident care areas (Attachment 6). Additionally, the DMS Facility Operations staff will continue to perform random environmental rounds and will conduct quarterly inspections of all resident care areas (Attachment 7). All environmental findings will be promptly addressed and communicated to staff and residents affected by actions taken to resolve any deficient areas ensuring that the residents needs are met. Communication will also be provided to all residents on the new grievance/complaint process so that they can report any environmental concerns. The DMS and Nursing staff will promptly document and track all work orders submitted through the AIM work order system. Success Evaluation The Risk Manager/Safety Officer or designee will verify that all submitted work orders that impact residents are completed promptly and accurately weekly for eight consecutive weeks. Any work orders that were not completed will be communicated to the Nursing Home	

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F 584	Continued From page 19	F 584	Administrator (NHA) for follow-up and to ensure timely completion. To ensure completeness and sustainability, an audit of 50% of the monthly work orders will be completed for three consecutive months. All audit results will be submitted to the Nursing Home Administrator (NHA) and Quality Assurance Department and the results will be reviewed at the monthly QAPI Committee meetings. If 100 percent compliance is not achieved, then the Risk Manager/Safety Officer or designee and NHA will meet with the DMS Facility Operations staff to determine the plan of action moving forward. If it is determined that 100 percent compliance is achieved, then we will conclude that we have successfully addressed this cited deficient practice. Item 3 Loud Disturbing Noise Dirty Linen Room Door Individual/Resident Impacted The facility failed to maintain a clean, comfortable and homelike environment as observed by a loud disturbing noise when closing the Candee 200 dirty linen door. A corrective action was immediately taken to address the deficient practice by initiating a work order number 19-122894 (Attachment 9) in the AIM work order system to resolve the loud disturbing noise on Candee 200 nursing unit. The DMS Facility Operations staff completed the work order that addressed the cited findings on November 07, 2018. The Nursing Home Administrator (NHA) and Charge Nurse on Candee 200 interviewed	

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F 584	Continued From page 20	F 584	R46 and R82 as well as all residents whose rooms are in close proximity to the loud door. All interviewed residents reported that the noise issue was addressed and resolved. Identification of other residents with the potential to be affected All residents have the potential to be affected by the deficient practice of the facility failing to maintain a quiet homelike and comfortable environment. The DMS Facility Operations staff immediately checked all residential areas for similar door closures to ensure that they were properly operable and safe for use. System Changes The root cause of the deficient practice was a lack of established system and procedures for conducting environmental inspections. An environmental checklist was developed for conducting environmental inspections specific to door closure in resident care areas. The Risk Manager/Safety Officer or designee will conduct monthly environmental inspections of all doors in resident care areas (Attachment 6). Additionally, the DMS Facility Operations staff will continue to perform random environmental rounds and will conduct quarterly inspections of all resident care areas (Attachment 7). All environmental findings will be promptly addressed and communicated to staff and residents affected by actions taken to resolve any deficient areas ensuring that the residents needs are met. Communication will also be provided to all	

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F 584	Continued From page 21	F 584	residents on the new grievance/complaint process so that they can report any environmental concerns. The DMS and Nursing staff will promptly document and track all work orders submitted through the AIM work order system. Success Evaluation The Risk Manager/Safety Officer or designee will verify that all submitted work orders that impact residents are completed promptly and accurately weekly for eight consecutive weeks. Any work orders that were not completed will be communicated to the Nursing Home Administrator (NHA) for follow-up and to ensure timely completion. To ensure completeness and sustainability, an audit of 50% of the monthly work orders will be completed for three consecutive months. All audit results will be submitted to the Nursing Home Administrator (NHA) and Quality Assurance Department and the results will be reviewed at the monthly QAPI Committee meetings. If 100 percent compliance is not achieved, then the Risk Manager/Safety Officer or designee and NHA will meet with the DMS Facility Operations staff to determine the plan of action moving forward. If it is determined that 100 percent compliance is achieved, then we will conclude that we have successfully addressed this cited deficient practice.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		1/3/19

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F 585	Continued From page 22 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585		

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F 585	Continued From page 23 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585		

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F 585	Continued From page 24 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on group and staff interviews and review of facility documentation, it was determined that the facility failed to have an established grievance policy or process of having information on how to file grievances anonymously. 6/1/15 - Facility policy entitled: Resident Concerns/Grievances (signed & approved 6/1/15) did not include the following required information: - notification of postings in prominent locations throughout the facility of the right to file grievances orally or in writing; - the right to file grievances anonymously; - the contact information of the grievance official with whom a grievance can be filed; - a reasonable expected time frame for completing the review of the grievance; - the right to obtain a written decision regarding his or her grievance; - the contact information of independent entities with whom grievances may be filed, i.e. State Agency, Ombudsman. February - October 2018: Review of the Resident Council meeting minutes revealed no evidence	F 585	Individual/Resident Impacted The facility failed to have an established grievance policy or process with information on how to file an anonymous grievance. The facility immediately corrected this deficient practice by posting, throughout the facility, details of the grievance policy, with instructions on how to file grievances orally, in writing, and/or anonymously. As of 11/8/18, Resident Concerns/Grievance locked boxes were placed in three designated locations throughout the facility, accompanied by a Resident/Family/ Grievance Form, which can be used by any resident or visitor who wishes to report any concerns or complaints. (Attachment 10) The Resident Concerns/Complaints/ Grievance policy was also updated to include the new grievance process as of 11/8/18. (Attachment 11) The Grievance Officer will be responsible for ensuring that the postings and Resident /Family/Grievance Forms remain accessible to all residents	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 25 regarding information on how to file a grievance. This process was not discussed with the residents. 11/1/18 2:00 PM: During the Resident Council Meeting, when asked if they knew how to file a grievance, the 13 (R109, R71, R53, R67, R35, R20, R82, R74, R98, R2, R75, R37 and R9) residents attending the meeting answered "no." It was further stated they could tell the social worker if they had a problem. When asked if they knew how to file a grievance anonymously, the response was "No." 11/2/18 11:30 AM: Interview with E1 (NHA) and E32 (Risk Manager) revealed that there was no system in place to ensure residents can file a grievance anonymously. E32 explained that each unit had a black box to place comments and that these boxes can be used for grievances, but there was no label or sign that indicated the box was for grievances or complaints. E1 confirmed that the facility policy for Resident Concerns/Grievances has not been updated since 2015. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 585	and visitors. Identification of other residents with the potential to be affected All residents in the facility have the potential to be affected by this deficient practice of not having an established grievance policy or process of having information on how to file grievances anonymously. All pertinent information related to the updated grievance process was made accessible to all residents and visitors in designated locations throughout the facility as of 11/8/18. System Changes The root cause of this deficient practice was lack of an updated grievance policy and process to include a designated Grievance Officer and information on how to file grievances anonymously. A Grievance Officer has been identified as part of the established grievance process and included in the updated policy. The establishment of the Grievance Officer and grievance process was communicated to all residents at the Resident Council Meeting on 11/13/18. The facility instituted postings with all updated pertinent information related to the grievance process and a new Resident/Family/Grievance form for any resident or visitor who wishes to report any concerns or complaints in writing and/or anonymously. The Grievance Officer or designee will check the Resident Concerns/Grievances locked boxes Monday through Friday for any reported concerns or complaints and will	

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F 585	Continued From page 26	F 585	investigate and follow-up within two business days or as soon as possible. (Attachment 12) The Grievance Officer will communicate the resolution or recommendation of the complaint to the individuals involved and maintain a record of the findings. The Grievance Officer/Hospital Social Services Administrator II or designee will review the updated grievance process with the residents who attend each monthly Resident Council Meeting. A copy of the posting will also be added into the resident monthly newsletters (The Chatter). Success Evaluation The Hospital Social Services Administrator II or designee will review all resident monthly newsletters (The Chatter) to ensure that the grievance process is accurately documented and communicated to the residents. The Continuous Quality Improvement Nurse (CQI RN II) will conduct random monthly observations to ensure that the postings and Resident/Family/Grievance forms remain accessible to residents and visitors in the designated locations for 6 consecutive months. The results will be reviewed at the monthly QAPI Committee and Quarterly QAPI Steering Committee meetings. If it is determined that 100 percent compliance is achieved for 6 consecutive months then we will conclude that we have successfully addressed this cited deficient practice.	
F 622	Transfer and Discharge Requirements	F 622		1/3/19

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F 622 SS=E	Continued From page 27 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 622		

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F 622	Continued From page 28 discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F 622		

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F 622	Continued From page 29 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure information was provided to the receiving provider for five (R11, R110, R42, R51 and R314) out of 53 sampled residents. The facility failed to include resident care plan goal in the transfer / discharge information. Findings included: The following residents were transferred / discharged from the facility and did not have evidence that the care plan goals were provided to the receiving provider: 1. R11 was admitted to the hospital on 4/26/18 2. R110 was admitted to the hospital on 10/18/18 3. R42 was transferred to the hospital on 2/13/18. 4. R42 was transferred to the hospital on 3/17/18. 5. R42 was transferred to the hospital for planned surgery on 7/11/18. 6. R314 was admitted to the hospital on 6/22/18. 7. R314 was admitted to the hospital on 10/16/18. 8. R51 was admitted to the hospital on 7/2/18.	F 622	Individual/Resident Impacted The facility failed to include resident care plan goals in the transfer/discharge information for R11, R110, R42, R314, and R51. Once this was brought to the facilitys attention, the facility immediately began including a copy of each residents care plan goals in the Transfer packet sent with residents when transferring/discharging to an acute care facility. The Operations Support Specialist (OSS) on each nursing unit updated every resident s Transfer Packet to include a copy of the residents care plan goals. Identification of other residents with the potential to be affected All residents in the facility have the potential to be affected by this cited deficient practice of omitting resident care plan goals in the transfer/discharge information. The Attending Nurse will review the resident s Transfer Packet prior to transferring/discharging to an acute care facility to ensure that the resident care plan goals are included. System Changes The root cause of this deficient practice	

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F 622	Continued From page 30 9. R51 was admitted to the hospital on 8/14/18. 10. R51 was admitted to the hospital on 9/21/18. 11/01/18 10:48 AM - An interview with E27 (RN, UM) and E24 (LPN) confirmed that there was no policy for what is sent to hospital when a resident is transferred, but the care plan goals are not sent. 11/01/18 11:05 AM E28 (Unit Clerk) provided a "transfer folder" that included a list of what needs to be sent to the hospital when a resident is transferred and confirmed that care plan goals are not sent. 11/1/18 12:10 PM - Surveyor interviewed E16 (RN, UM) and asked about policies and procedures when transferring a resident to the hospital and if the procedure included sending the care plan goals with the transfer papers. 11/2/18 12:15 PM Surveyor interviewed E17 (Hospital Social Services Admin II) and asked about policies and procedures during a transfer and discharge. E17 stated that "Nursing gives us a copy of the letter regarding bed hold notice that we give out to the residents, family or guardian when a resident is being transferred to the hospital. That's all we give out ..." 11/5/18 8:00 AM - Surveyor interviewed E1 (NHA) and asked about policies and procedures when transferring a resident to the hospital and if the procedure included sending the care plan goals with the transfer papers. E1 said that they do not have a specific policy and procedure on transferring residents to the hospital. E1 further stated "We do not send the care plan goals. We	F 622	was a knowledge deficit regarding the new requirement that care plan goals must be included in the transfer/discharge information sent to the receiving provider. A new Resident Transfer Packet has been created for each resident, which now includes resident care plan goals. The Attending Nurse will now be responsible for ensuring that care plan goals are included in all Transfer Packets sent with residents to an acute care facility. All licensed staff will receive training regarding this new procedure by the Director of Nursing and Assistant Director of Nursing by January 03, 2019. Success Evaluation All residents Transfer Packets will be updated by the Operations Support Specialist (OSS) on each nursing unit on a monthly basis to ensure that each residents Transfer Packet contains the resident care plan goals. Staff will be required to sign and date a verification that each resident s Transfer Packet has been updated to include the resident care plan goals. The Continuous Quality Improvement Nurse (CQI RN III) or designee will complete random monthly audits of 25 percent of the residents Transfer Packets using the Nursing Services Audit Tool (Attachment 13) to ensure that 100 percent compliance has been maintained for 10 consecutive weeks and thereafter on a monthly basis. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100	

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F 622	Continued From page 31 go by what the Division of Long Term Care gave us. There's a packet that we use with instructions on what to send - that we fill out and complete when we transfer residents to the hospital." Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 622	percent compliance is achieved for 4 consecutive months then we will conclude that we have successfully addressed the cited deficient practice	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		1/3/19

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F 623	Continued From page 32 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance	F 623		

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F 623	Continued From page 33 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, and interview, it was determined that the facility failed to ensure information and notifications were provided to the resident / responsible party for five (R11, R110, R42, R51 and R314) out of 53 sampled residents. The facility failed to provide discharge / transfer notice that included reason; location; statement of appeal rights; Ombudsman information; and advocacy agencies as indicated. Findings included:	F 623	Individual/Resident Impacted The facility failed to ensure information and notifications were provided to the resident/responsible party, and failed to provide a discharge/transfer notice that included reason, location, statement of appeal rights, Ombudsman information, and advocacy agencies for R11, R10, R42, R51, and R314. The facility immediately corrected this deficient	

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F 623	Continued From page 34 Facility policy for Bed-Hold and Readmission (dated 8/29/17) stated When a resident is temporarily transferred on an emergency basis to an acute-care facility a Bed-Hold Notification Letter for emergency transfers will be sent to the LTC Ombudsman when practicable. The following residents were transferred / discharged to the facility and did not have evidence that the required discharge / transfer notice was provided to the resident / responsible party or to the State Long - Term Ombudsman: 1. R11 was admitted to the hospital on 4/26/18 2. R110 was admitted to the hospital on 10/18/18 3. R42 was transferred to the hospital on 2/13/18. 4. R42 was transferred to the hospital on 3/17/18. 5. R42 was transferred to the hospital for planned surgery on 7/11/18. 6. R314 was admitted to the hospital on 6/22/18. 7. R314 was admitted to the hospital on 10/16/18. 8. R51 was admitted to the hospital on 7/2/18. 9. R51 was admitted to the hospital on 8/14/18. 10. R51 was admitted to the hospital on 9/21/18. The facility failed to provide discharge / transfer notices to the above mentioned residents. 10/31/18 3:10 PM - Interview with E17 (Hospital	F 623	practice by implementing a Transfer Log to document that the facility notified the Long Term Care Ombudsman s Office. The Bed Hold Notification Letter (Attachment 14) and policy (Attachment 15) were updated to include the reason, location, statement of appeal rights, Long Term Care Ombudsman contact information, and advocacy agencies on December 3, 2018. Identification of other residents with the potential to be affected All residents in the facility have the potential to be affected by this cited deficient practice of not ensuring information and notifications were provided to the resident/responsible party and by not providing discharge/transfer notices that include reason, location, statement of appeal rights, Ombudsman information, and advocacy agencies. The Hospital Social Services Administrator II updated the facilitys current Bed Hold Notification Letter and policy to ensure that the letter now includes all necessary information. In addition, a Transfer Log was also implemented to document notification to the Long Term Care Ombudsman s Office upon resident discharge/transfer. System Changes The root cause of this deficient practice was a knowledge deficit regarding the new requirement that Transfer/Discharge notices must include reason, location, statement of appeal rights, Ombudsman information, and advocacy agencies and	

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F 623	Continued From page 35 Social Services Admin II) revealed that when a resident is admitted to the hospital the facility does not send to the resident or resident representative(s) a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The facility also does not send a copy of the notice of transfer to the Office of the State Long Term Ombudsman. 11/2/18 12:15 PM - Surveyor asked E17 (Hospital Social Services Admin II) about transfers and discharges and if the procedure included sending copy of notices to the Office of the State Long Term Ombudsman in the event there is a death in the facility as a discharge. E17 stated that "We only notify the Ombudsman when we know ahead of time that we will be discharging the resident back to the community. We do not notify them of death happening in the facility as a discharge. We do not notify the Ombudsman when a resident is transferred to the hospital." 11/2/18 12:32 PM - Surveyor interviewed E25 (RN Supervisor) and stated that "We do not notify the Ombudsman when a resident expires in the facility. Nursing did not notify the Ombudsman when R114 expired on 10/7/18." 11/5/18 9:00 AM - E17 explained to another Surveyor that Social Service sends Notice of Discharge to residents who are being discharged back to the community and copies of the notices are sent to the Ombudsman. Social Service do not send notices to the Ombudsman for transfers to the hospital.	F 623	that the Long Term Care Ombudsman s Office must receive notification of the transfer/discharge. A new Transfer Log has been created which includes the following information: resident name, location of transfer, notice to resident date, transfer date, return to facility date, and reason for transfer. (Attachment 16) The Hospital Social Services Administrator II will now be responsible for ensuring completion of the Transfer Log and providing a copy of the Transfer Log to the Long Term Care Ombudsman s Office on a monthly basis. Prior to the Transfer Log being provided to the Long Term Care Ombudsman s Office, the Continuous Quality Improvement Nurse (CQI RN III) will review the Transfer Log and verify it for content accuracy. The updated Bed Hold Notification Letter will be used and provided to all residents or their legal representatives when residents are transferred/discharged to the acute care facility. Training in-services on the Bed Hold Notification Letter, Transfer Log, and utilization of the Bed Hold and Readmission Policy will be conducted by the Training Administrator II for all licensed nursing staff and Social Services staff by January 15, 2019. Success Evaluation A copy of each month s verified Transfer Log and the documentation verifying that the Log was provided to the Long Term Care Ombudsman s Office will be filed in the Hospital Social Services Administrator II s office. A copy of each month s Transfer Log and documentation will be	

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F 623	Continued From page 36 11/5/18 at approximately 2:57 PM - An interview with E7 (RN, UM) confirmed the above findings. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 623	submitted to the Nursing Home Administrator (NHA), Hospital Administrator II, and Quality Assurance Department. The Continuous Quality Improvement Nurse (CQI RN III) will continue to review the Transfer Log and supporting documentation monthly to ensure that 100 percent compliance has been maintained for 6 consecutive months and thereafter on an annual basis. The results will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for 6 consecutive months then we will conclude that we have successfully addressed the cited deficient practice.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R50, R110 and R104) out of 53 sampled residents the facility failed to ensure the accuracy of the MDS assessment. Findings include: 1. The following was reviewed in R110's clinical record: 6/4/18 - Yearly History and Physical documented dementia with psychosis and depression. 7/20/18 - Annual MDS documents dementia and	F 641	Item 1 Review of R110s Diagnosis List Individual/Resident Impacted The facility failed to ensure the accuracy of the MDS assessment for R110. The History and Physical for R110 documented dementia with psychosis and depression. However, the annual and quarterly MDS was incorrectly coded as Dementia and Psychotic Disorder. A thorough chart review of R110 was completed and a corrected MDS was submitted (Attachment 17) on 11/16/18 by the Registered Nurse Assessment	1/3/19

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F 641	Continued From page 37 psychotic disorder. 10/12/18 - Quarterly MDS that documents dementia and psychotic disorder. Review of R110's diagnosis list in the record did not include a psychotic disorder. 10/30/18 1:50 PM - Interview with E14 (MD) revealed that R110 has delusion thinking and paranoia related to dementia. 11/01/18 2:05 PM - Interview with E26 (RN, UM) confirmed that R110 does not have a psychotic disorder but does have dementia with psychosis that should not be documented on the MDS as a psychotic disorder. This was confirmed by E6 (RNAC) who approached during the conversation. 2. The following was reviewed in R50's clinical record: 11/9/17 - Annual Physical documents in the History section that R50's behavior problems are due to dementia with psychosis. The Assessment and Plan section documents Vascular type Dementia with psychosis: worsening with aging. 8/31/18 - quarterly MDS documents a diagnosis of Psychotic disorder. 11/1/18 2:45 PM - During an interview with E17 (Social Services) reviewed Social Service's copy of R50's admission records to confirm that did not include a psychotic disorder.	F 641	Coordinator (RNAC), removing the inaccurate diagnosis of Psychotic Disorder. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice. All residents with neurocognitive disorder with behavioral disturbance, which were previously documented in the history and physical as dementia with psychosis, were reviewed and revised to reflect accurate MDS coding. All other previously submitted MDS that were found to be inaccurate, were updated and resubmitted with the appropriate codes. System Changes The root cause of this deficient practice is a knowledge deficit related to correct coding for residents with the written diagnosis of dementia with psychosis. The facility RNACs were in-serviced by the Director of Nursing and Psychologist, for proper coding of residents who have this diagnosis. All residents with the diagnoses of dementia with psychosis have been reviewed by the Psychotropic Medication Advisory Committee (PMAC) consisting of the Psychologist, Behavioral Health Nurse Supervisor and Pharmacist to reflect the accurate ICD-10 code of Neurocognitive Disorder with behavioral disturbances. All diagnoses have been revised by Medical Record Technicians to update the History and Physical with the correct ICD-10 diagnosis, which will allow for the most accurate MDS coding.	

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F 641	Continued From page 38 3. The following was reviewed in R104's clinical record: 7/12/18 - Admission history and physical: R104 was admitted to facility in a chronic vegetative state with a tracheostomy. . 7/18/18 - Admission MDS documented incorrectly in the area of Self-Performance of Activities of Daily Living that R104 needed extensive assistance with transferring. R104 actually was totally dependent for transferring. 11/05/18 12:45 PM - Interview with E4 (RNAC) confirmed the above MDS error because R104 was totally dependent for transferring. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 641	Success Evaluation In response to this citation, DHCI has completely revised their MDS submission process. Prior to the MDS due date, the PMAC will complete a chart review to ensure that diagnoses/ICD-10 codes in the History and Physical and Physician Order Sheets are accurate. Prior to MDS submission, the RNAC is responsible for validating any changes in the MDS coding. The PMAC will follow-up by auditing Section I of the MDS for accuracy of coding related to Psychiatric diagnosis for (8) consecutive weeks. If 100 percent compliance is not achieved, then the Director of Nursing or designee will re-assign the responsibility of coding Section I to the PMAC. We will then transition the audit to 50% of the monthly MDS submissions for (3) consecutive months. Any discrepancies found will be brought to the attention of the Director of Nursing or designee for corrective action. The results of this review will be reported at the monthly QAPI committee meetings. If the audits indicate that we have sustained 100% compliance for (4) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice. Item 2 R50s Clinical Record Individual/Resident Impacted The facility failed to ensure the accuracy of the MDS assessment for R50. The History and Physical for R50 documented dementia with psychosis, and the assessment and plan section documented	

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F 641	Continued From page 39	F 641	vascular type dementia with psychosis, worsening with aging. The quarterly MDS was incorrectly coded as Psychotic Disorder. A thorough chart review of R50 was completed and a corrected MDS was submitted (Attachment 17) on 11/16/18 by the Registered Nurse Assessment Coordinator (RNAC) removing the inaccurate diagnosis of Psychotic Disorder. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice. All residents with neurocognitive disorder with behavioral disturbance, which were previously documented in the history and physical as vascular type dementia with psychosis, were reviewed and revised to reflect accurate MDS coding. All other previously submitted MDS that were found to be inaccurate, were updated and resubmitted with the appropriate codes. System Changes The root cause of this deficient practice is a knowledge deficit related to correct coding for residents with the written diagnosis of vascular type dementia with psychosis. The facility RNACs were in-serviced by the Director of Nursing and Psychologist, for proper coding of residents who have this diagnosis. All residents with the diagnoses of vascular type dementia with psychosis have been reviewed by the Psychotropic Medication Advisory Committee (PMAC) consisting of the Psychologist, Behavioral Health Nurse	

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F 641	Continued From page 40	F 641	Supervisor and Pharmacist to reflect the accurate ICD-10 code of Neurocognitive Disorder with behavioral disturbance. All diagnoses have been revised by Medical Record Technicians to update the History and Physical with the correct ICD-10 diagnosis, which will allow for the most accurate MDS coding. Success Evaluation In response to this citation, DHCI has completely revised their MDS submission process. Prior to the MDS due date, the PMAC will complete a chart review to ensure that diagnoses/ICD-10 codes in the History and Physical and Physician Order Sheets are accurate. Prior to MDS submission, the RNAC is responsible for validating any changes in the MDS coding. The PMAC will follow-up by auditing Section I of the MDS for accuracy of coding related to Psychiatric diagnosis for (8) consecutive weeks. If 100 percent compliance is not achieved, then the Director of Nursing or designee will re-assign the responsibility of coding Section I to the PMAC. We will then transition the audit to 50% of the monthly MDS submissions for (3) consecutive months. Any discrepancies found will be brought to the attention of the Director of Nursing or designee for corrective action. The results of this review will be reported at the monthly QAPI committee meetings. If the audits indicate that we have sustained 100% compliance for (4) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice.	

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F 641	Continued From page 41	F 641	Item 3 Admission history and physical R104 Individual/Resident Impacted The facility failed to ensure the accuracy of the admission MDS assessment for R104. The RNAC coded the MDS assessment inaccurately in the area of Self Performance for transferring as needing extensive assistance. R104 is totally dependent for transferring. The RNAC corrected the coding error on the admission assessment and resubmitted (Attachment 17) it on 11/19/2018. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice of inaccurate MDS assessment. A chart review of all residents in the area of self-performance of Activities of Daily Living for transferring was completed by the Continuous Quality Improvement Nurse (CQI RN III) and no discrepancies in MDS coding were found. System Changes The root cause for this cited deficiency is the failure to validate the accuracy of the MDS admission assessment. The Registered Nurse Assessment Coordinator (RNAC) was in-serviced by the Director of Nursing regarding MDS coding accuracy. The RNAC was reminded of the importance of validating the resident assessment prior to completing the MDS to ensure coding accuracy. The RNACs will review all new	

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F 641	Continued From page 42	F 641	completed admission assessments with the DON for accuracy prior to the final MDS submission. Success Evaluation All completed admission MDS assessments specific to Section G (Self-Performance of Activities of Daily Living) will be reviewed weekly for accuracy for (10) consecutive weeks by the Continuous Quality Improvement Nurse (CQI RN III). If we have not achieved 100 percent compliance, the Director of Nursing or designee will determine the need for additional training related to MDS submission. We will then transition the audit to 100% of the admission MDS assessments specific to Section G for (3) consecutive months. The results of this review will be reported at the monthly QAPI committee meetings. If the audits indicate that we have sustained 100% compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		1/3/19

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F 656	Continued From page 43 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation for one (R104) out of 56 sampled residents the facility failed to develop comprehensive care plans that included specific interventions for tracheostomy care.	F 656	Individual/Resident Impacted The facility failed to develop an accurate care plan related to R104s tracheostomy care. R 104s care plan was immediately revised and updated to include interventions for routine and emergent	

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F 656	Continued From page 44 Findings include: 7/12/18 - R104 Admitted to facility in a vegetative state with a tracheostomy. 10/31/18 at 1:00 PM - E27 (RN, UM) provided copy of R104's care plan which did not include resident specific monitoring of respiratory status such as type and size of airway or address resident specific approaches for complications such as unplanned extubation. 11/5/18 11:30 AM Interview with E20 (RN Supervisor) and E27 (RN, UM) confirmed above findings. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 656	tracheostomy care. Identification of other residents with the potential to be affected All residents with a tracheostomy have the potential to be affected by this deficient practice of not having a comprehensive care plan that includes interventions for tracheostomy care. A review of the care plans for all residents with tracheostomies was completed on 12/1/18 and the care plans were updated as needed with interventions for routine and emergent tracheostomy care. System Changes The root cause of the deficient practice is a knowledge deficit related to developing comprehensive care plans with appropriate interventions for tracheostomy care. All licensed staff will be in serviced on tracheostomy care, including correct care plan interventions for routine and emergent tracheostomy care planning. DHCI initiated a new electronic charting system (ECS) in mid-October 2018. The transitioning of developing appropriate person centered care plan interventions, within the American Data ECS system will be completed by December 20, 2018. The ECS system will aid in the development of person centered care plans. Success Evaluation Nursing tracheostomy care competencies will be completed annually for licensed staff. The Continuous Quality Improvement Nurse (CQI RN III) will	

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F 656	Continued From page 45	F 656	complete monthly audits of 100% of the care plans for residents with tracheostomies for (4) consecutive months. If we have not achieved 100% compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to care planning of tracheostomy care. We will then conduct quarterly audits for 100% of the care plans for residents with tracheostomies for (2) quarters to ensure sustainability. The results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have maintained 100% compliance for (2) consecutive quarters, then the facility will conclude that we have successfully addressed this deficient practice.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		1/3/19

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F 657	Continued From page 46 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for four (R95, R11, R110 and R51) out of 53 sampled residents, the facility failed to review and revise the care plan. The facility also failed to ensure that the care plan was developed by an IDT that included the attending physician and a nurse aide with responsibility for the resident. Findings include: 1. Review of R95's clinical record revealed: Cross refer F686, Example #1. 5/4/16 - R95 was admitted to the facility. 7/10/18 - A wound evaluation, by E10 (Wound Care Consultant), documented a previously healed stage 4 PU (healed less than 6 months ago), which reopened. 10/5/18 - Care plan for skin care, documented that R95 had fragile skin and had an existing skin injury. The approaches included monitor turning and repositioning, the CNA to help reposition at least every 1-2 hours while in bed, elevate heels in bed, and to ensure R95's position was changed frequently.	F 657	Item 1 Facility failed to review and revise care plan Individual/Resident Impacted The facility failed to update and revise R95s care plan. The care plan lacks specific interventions and approaches as to how R95 should be turned from side to side only and to sit up for meals for no longer than 1 hour. The care plan was immediately revised and updated by the wound care nurse on 11/02/18, to include approaches to sit up for meals and side to side turns when in bed. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice of not updating the care plan to include recommended interventions. A chart review of all dependent residents and those with impaired skin integrity on a turn and repositioning schedule was completed on 12/7/18 to ensure the care plan was updated to include specific interventions and approaches.	

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F 657	Continued From page 47 10/16/18 - Wound evaluation documented, additional recommended approaches, which included, only turning R95 from side to side and only to sit up for meals only for no longer than 1 hour. Record review lacked evidence that that above care plan was reviewed and revised, to include the approaches to turn R95 side to side only and to sit up for meals no longer than 1 hour. 10/23/18 - Wound evaluation documented, additional recommended approaches of sitting for meals only, side to side turn only; when in bed and to document refusals. Record review lacked evidence that the above care plan was reviewed and revised, to include the approaches to sit up for meals only and side to side turn only; when in bed. 11/02/18 at 2:15 PM- An interview with E9 (RN, WCN) was conducted. E9 confirmed that the current turning and repositioning schedule, for R95 was side to side turn only and that R95 was not to be placed on his back. In addition, R95 to be up only for meals. E9 verbalized, that the Nursing Care Plan was to be updated by the Unit Manager and confirmed the care plan did not include these approaches. 11/5/18 at approximately 3:30 PM - An interview with E7 (RN, UM) was conducted. E7 confirmed that the facility failed to have evidence, that the above care plan was revised, to include the approaches to limit sitting only for meals and side to side turning only while R95 was in bed.	F 657	System Changes The root cause of this deficient practice is a lack of a standardized system and process in place related to reviewing and revising care plans to incorporate the recommendations from the wound care team. A new procedure was developed to include a member of the wound care team or designee to review and update the current plan of care related to skin and wound interventions. If any discrepancies are found they will be corrected immediately. Success Evaluation The Continuous Quality Improvement Nurse (CQI RN III) will complete weekly audits of 100% of the care plans for residents being followed by the wound care team for (8) consecutive weeks at the IDT meetings. If we have not achieved 100% compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to care planning for recommended skin and wound care interventions. We will then conduct monthly audits for 100% of the care plans for residents being followed by the wound care team for (3) months to ensure sustainability. The results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have maintained 100% compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice.	

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F 657	Continued From page 48 2. The following was reviewed in R110's clinical record: 7/20/18 - Annual MDS 8/1/18 - IDT Meeting document noted E26 (RN, UM) attended but no CNA attended. 10/12/18 - Quarterly MDS 10/24/18 - IDT Meeting document noted E26 (RN, UM) attended but no CNA Attended. 11/1/18 2:16 PM - Interview with E26 (UM, RN) revealed that she was at the October meeting and no CNA attended. E26 stated that there have been meetings where a restorative aide has attended. E26 went on to add that she has been on the unit a year and has not had a CNA attend an IDT meeting. 3. The following was reviewed in R11's clinical record: 8/3/18 - Annual MDS 8/15/18 - IDT meeting documented nurse attended but no CNA or MD / NP attended. 10/26/18 - Quarterly MDS No meeting information was available for the 10/26/18 MDS. 11/5/18 11:59 AM - Interview with E2 (DON) reviewed an IDT sign in sheet with no CNA in attendance. E2 stated that if a resident comes to the meeting on their own an aide might not come. When asked about the MD or NP attending the	F 657	Item 2 MDS and IDT Documentation R110 Individual/Resident Impacted The facility failed to ensure that the care plan was developed by an IDT team that included a nurse aid who was responsible for the resident. This was an omission on the part of the facility to have the CNA attend the IDT meetings for R110. Beginning 11/7/2018 CNAs attendance was made mandatory at all IDT meetings. Identification of other residents with the potential to be affected All residents in the facility have the potential to be affected by this deficient practice of not developing an interdisciplinary care plan to include the CNA responsible for the residents care. The DON has implemented an IDT attendance requirement to include the CNA responsible for patient care. System Changes The root cause of this deficient practice is a knowledge deficit, related to the requirement that a CNA caring for the resident must attend the interdisciplinary team meeting. The DON will review the attendance roster for each weekly IDT meeting to ensure that the attendance requirement was met. Success Evaluation The Nursing Supervisor and/or the Social Worker coordinating the Interdisciplinary Team (IDT) meetings will ensure that the signatures of all attendees are captured on the care plans. The Director of	

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F 657	Continued From page 49 IDT it was revealed that they do come "at times" and would sign in if they were there. 3. Review of R51's clinical records revealed: R51 is a long term care resident admitted to the facility on 2/19/13 with Cerebrovascular Accident (stroke), and is on tube feeding. 4/12/13 revised on 3/29/16 - R51 was care planned for Alteration in Nutrition: Tube Feeding. Interventions included ..."RD (Registered Dietitian) will recommend appropriate formula and fluid amounts based on resident's current nutritional needs and known tolerances. Type: Nepro Full Strength, Amount: Total Volume: 800 ml/24 hours, Feeding to be started at 5:00 PM ..." (revised on 8/22/18) 10/1/18 - R51 has an enteral feeding order documented in the October 2018 Physician Order Sheet (POS) and in the Medication Administration Record (MAR) enteral sheet signed off by E16 (RN, UM) as " 10/1/18 Nepro full strength, for total volume 900 ml/24 Start feeding at 1700 (5PM)." 11/5/18 11:00 AM - Surveyor asked E15 (Nutritionist) and E16 (RN, UM) regarding the October 1, 2018 enteral feeding order. E15 and E16 both confirmed that the total volume of enteral feeding was changed on 10/1/18 from 800 ml/24 hours to 900ml/24 hours and further confirmed that the careplan was not updated and revised. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 657	Nursing (DON) or designee will complete weekly audits of 100% of all resident care plans that are reviewed during their scheduled IDT meetings for (8) consecutive weeks. If we have not achieved 100% compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to the importance of capturing the signatures of all required IDT meeting attendees. We will then conduct monthly audits for 100% of the resident care plans for (3) months to ensure sustainability. The results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have maintained 100% compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice. Item 3 - MDS and IDT Documentation R11 Individual/Resident Impacted The facility failed to ensure that the care plan was developed by an IDT team that included the Physician or designee and CNA who were responsible for the resident. This was an omission on the part of the facility to have the Physician or designee and the CNA attend the IDT meetings for resident R11. As of 11/7/2018, Physician/NP and CNA attendance is mandatory at all IDT meetings. Identification of other residents with the potential to be affected All residents in the facility have the	

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F 657	Continued From page 50	F 657	potential to be affected by this deficient practice of not developing an interdisciplinary care plan to include the Physician and CNA responsible for the residents care. The DON has implemented an IDT attendance requirement to include the CNA responsible for patient care. System Changes The root cause of this deficient practice is a knowledge deficit, related to the requirement that a Physician and CNA caring for the resident must attend the interdisciplinary team meeting. The DON will review the attendance roster for each weekly IDT meeting to ensure that the attendance requirement was met. Success Evaluation The Nursing Supervisor and/or the Social Worker coordinating the Interdisciplinary Team (IDT) meetings will ensure that the signatures of all attendees are captured on the care plans. The Director of Nursing (DON) or designee will complete weekly audits of 100% of all resident care plans that are reviewed during their scheduled IDT meetings for (8) consecutive weeks. If we have not achieved 100% compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to the importance of capturing the signatures of all required IDT meeting attendees. We will then conduct monthly audits for 100% of the resident care plans for (3) months to ensure sustainability. The results of these audits will be	

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F 657	Continued From page 51	F 657	reported at the monthly QAPI Committee meetings. If the audits indicate that we have maintained 100% compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice. Item 4 R51 Care Plan Revision Individual/Resident Impacted The facility failed to review and revise the care plan for R51 based upon the physicians enteral feeding order. Immediately upon notification of the care plan inaccuracy, the Unit Manager updated R51s care plan to include the correct enteral feeding as ordered by the physician on 11/5/18. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice of not updating the care plan specific to enteral feedings. A sweep of care plans for the residents receiving enteral feedings was completed on 12/7/2018 to ensure the care plans were correctly revised and updated. System Changes The root cause of this deficient practice is the lack of a standardized system and process in place related to reviewing and revising care plans to incorporate the recommendations from the Registered Dietitian. A new care plan process and procedure has been developed that will notify licensed staff of specific recommendations and new orders. This	

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F 657	Continued From page 52	F 657	procedure will ensure that no new physician orders are omitted from the care plan. All licensed staff will be in serviced on this new procedure by the Registered Dietitian or Trainer educator III. These in-services will be completed by 1/3/2019. Success Evaluation The Registered Dietitian and/or Continuous Quality Improvement Nurse (CQI RN III) will complete weekly audits of 100% of the care plans specific to residents receiving enteral feedings for (8) consecutive weeks to ensure that all of the recommendations or physician orders have been implemented and the care plans updated. If we have not achieved 100% compliance, the Registered Dietician or designee will determine the need for additional training related to current care plan interventions for residents receiving enteral feedings. We will then conduct monthly audits of 100% of the care plans specific to residents receiving enteral feedings for (3) months to ensure sustainability. The results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have maintained 100% compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		1/3/19

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F 686	Continued From page 53 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, interviews and review of other documentation as indicated, it was determined that for two (R95 and R88) out of 53 sampled residents, the facility failed to ensure that a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice to promote healing and prevent infection. Findings include: 1. Review of R95's clinical record revealed: Cross refer F657, Example #1 5/4/16 - R95 was admitted to the facility. 7/10/18 - A wound evaluation, by E10 (Wound Care Consultant), documented a previously healed stage 4 PU (healed less than 6 months ago), which reopened. 7/13/18 - The annual MDS assessment stated, R95 was moderately impaired for daily decision making with BIMS score of 9, required extensive assistance one staff person for bed mobility, total assistance of two staff persons for transfer, and had one, stage 4 PU.	F 686	F-686 Item 1 Skin Integrity/Pressure Ulcer Individual/Resident Impacted The facility failed to ensure that R 95 received the necessary treatment and services consistent with professional standards to promote healing and prevent infection of his pressure ulcers. The facility failed to follow wound care recommendations specific to residents special turn and repositioning schedule and to be up for meals for no longer than an hour. The CNA reference sheet and care plan was immediately updated by wound care nurse to include wound care recommendations. Nursing staff were reminded of the new updated wound care recommendations. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice of not following wound care recommendations to promote healing and prevent infection. A	

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F 686	Continued From page 54 9/28/18 - The significant change MDS assessment stated R95 was moderately impaired for daily decision making, required total assistance of one staff for bed mobility, total assistance of two staff persons for transfer, and continued to have one, stage 4 PU. 10/2/18 - The wound evaluation documented, a stage 4 PU of the coccyx, which worsened, related to size from previous weekly evaluation. The recommendation included changing the treatment, as well as to limit time in the chair for 2 hours only and to document refusal. This documentaiton contained the initials of E19 (NP) and a date of 10/3/18. Record review lacked evidence that the recommendations to limit time in the chair to only 2 hours was implemented. 10/5/18 - Care plan for skin care documented that R95 had fragile skin and had an existing skin injury. The approaches included monitor turning and repositioning, the CNA to help reposition at least every 1-2 hours while in bed, elevate my heels in bed, and to ensure R95's position was changed frequently. 10/16/18 - Wound evaluation documented, a stage 4 PU of coccyx, with slight improvement, due to decrease in depth of the PU. Recommendation was to continue the current treatment and in addition, to only turn R95 from side to side and only to sit up for meals only for no longer than 1 hour. The documentation contained the initials of E14 (MD) and E9 (RN, WCN) and a date of 10/16/18. Record review lacked evidence that the	F 686	chart review was conducted to ensure that no other resident was affected as a result of this deficient practice. This chart review was conducted by the wound care nurse on 12/5/18 to ensure that all recommendations from the wound care team were implemented. System Changes The root cause of this deficient practice is a failure to update the care plan and CNA Turn / Reposition Flow Record to reflect the most recent wound care recommendations. All wound care recommendations will be reviewed by a member of the wound care team or designee. The new recommendations will be implemented to include educating responsible staff, updating the care plan, and reviewing all documentation records related to promoting the healing, and preventing the infection of the wounds. The CNA Turn / Reposition Flow Record (Attachment 18) has been revised to reflect the comprehensive, person centered, wound care recommendations. Success Evaluation The Continuous Quality Improvement Nurse (CQI RN III) will complete weekly audits of 100 percent of the updated care plans and CNA Turn/Reposition Flow Records for residents being followed by the wound care team to assure they include current wound care recommendations for (8) consecutive weeks at the IDT meetings. If we have not achieved 100 percent compliance, the Director of Nursing (DON) or designee will	

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F 686	Continued From page 55 recommendations for side to side turn, supine and sit only meals only no longer than 1 hour was implemented. 10/23/18 - Wound evaluation documented a stage 4 PU of coccyx, which was worsening with new undermining. Recommendation was to continue the current treatment, as well as performing the treatment as needed. Additional recommendations included sitting for meals only, side to side turn only; when in bed and to document refusals. The document contained the initials of E14 (MD), E9 (RN, WCN) and date of 10/23/18. Record review lacked evidence that the recommendations for sitting for meals only, side to side turn only; when in bed was implemented. 10/2018 - CNA Reference Sheet (A care delivery guide for the CNAs), under "Skin", documented that R95 had a PU of the coccyx area and required one staff person to assist with turning. No further information was included on this documentation. 10/2018 - CNA Turn/Reposition Flow Record revealed to turn, reposition R95 in bed or chair and check skin condition every 2 hours and report abnormalities to the nurse. To reposition R46 in bed or chair every 2 hours. Use draw sheet to reposition him and report any changes in skin condition to nurse. The turn record was signed off by staff every day of the month. 11/1/18 at approximately 11:30 AM - R95 observed, lying on his back, with head of bed elevated at approximately 45 degrees. 11/02/18 at approximately 12:15 PM - R95 was	F 686	determine the need for additional education related to skin and wound care interventions to prevent and heal pressure ulcers. We will then conduct monthly audits for 100 percent of the care plans for residents being followed by wound care for (3) months to ensure sustainability. The results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have maintained 100 percent compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice. Item 2a. Multiple Skin Ulcers R88 Individual/Resident Impacted The facility failed to utilize proper wound care technique to prevent the risk of infection when completing wound care for R88. The nurse completing the treatment was given an immediate refresher course on proper wound care technique by the Unit Manager. She was able to demonstrate proper wound care technique on R88 while being observed by the wound care nurse on 12/6/18. Identification of other residents with the potential to be affected All residents with wounds have the potential to be affected by this deficient practice of not utilizing the correct wound care technique to prevent the risk of infection. All licensed staff will go through a refresher course demonstrating the correct way to complete a dressing to	

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F 686	Continued From page 56 observed, up in a chair. 11/2/18 at approximately 12:18 PM - An interview with E13 (CNA) revealed, that R95's current PU had previously healed and now it reopened. E13 was informed by E7 (RN, UM), that R95 was allowed to sit up in the chair, for approximately 1.5 to 2 hours, due to the coccyx PU. E13 verbalized that R95 has been up since 11:30 AM. E13 further reported that R95 relied on staff for turning and repositioning. E13 indicated that R95 was turned and repositioned, every two hours from left, to back, and then to right. When asked if R95 refused to be turned and repositioned and E13 replied, "he never refuses for me." E13 proceeded to show the surveyor, the CNA Turn/Reposition Flow Record and indicated that R95 was on a routine schedule, which was turning and repositioning every 2 hours. 11/02/18 at 12:26 PM - Surveyor observed E13 starting to feed R95 with his meal. At approximately 1 PM, the meal was completed and R95 was placed back to bed at 1:17 PM and positioned to left side. 11/02/18 at 2:15 PM- An interview with E9 (RN, WCN) was conducted. E9 confirmed that the current turning and repositioning schedule, for R95 was side to side turn only and that R95 was not to be placed on the back back. In addition, R95 was to be up only for meals. E9 verbalized, that the facility's system was, that he CNA Turn/Reposition Flow Record was updated by the Restorative Nursing Department and the CNA Reference Sheet and the Nursing Care Plan was to be updated by the Unit Manager. E9 confirmed all three areas of documentation were not revised, to include the interventions to	F 686	prevent infection according Association for Professionals in Infection Control and Epidemiology (APIC) guidelines. Licensed staff will be trained by the Director of Nursing, Trainer Educator III or designee by January 03, 2019. System Changes The root cause of this deficient practice is a knowledge deficit on proper wound care technique to prevent the risk of infection. The wound care nurse or designee will do periodic observations of wound care to ensure compliance with proper wound care techniques to prevent infection. Licensed nurses will complete an annual in-service on wound care techniques. All newly hired licensed staff shall be oriented on the policy and procedure of proper wound assessment and dressing changes. Success Evaluation The Wound Care Nurse, Infection Control Preventionist (ICP), or designee will complete (5) weekly wound care observations for (8) consecutive weeks to ensure that we are compliant with the Infection Control Policy and APIC guidelines to prevent infection. If we have not achieved 100 percent compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to proper wound care techniques to prevent the risk of infection. We will then conduct (5) monthly wound care observations for (3) months to ensure sustainability. The results of these audits will be reported at the monthly QAPI	

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F 686	Continued From page 57 promote healing of R95's PU. 11/5/18 at 9:05 AM - R95 was observed, with his eyes closed, on his back, with a clothing protector on his chest. 11/5/18 at 9:10 AM - A subsequent interview with E13 (CNA) was conducted. E13 was asked, if there has any change in the R95's turning and repositioning schedule and E13 indicated that E13 did not know, as she did not work this past weekend. A subsequent review of the CNA Reference Sheet, with E13, revealed hand written revisions, documenting turn and position every 1-2 hours, side to side only while in bed. In addition, the CNA Turn/Reposition Flow Record was reviewed, which documented, turn and reposition, every 1-2 hours, side to side only while in bed, with a date of 11/2/18. Although the facility revised the above documentation, record review lacked evidence, of an intervention for siting for meals only. 11/5/18 at approximately 1:15 PM - An interview with E20 (RNM) revealed that R95 was not receiving restorative nursing services, thus, their department would not revise the CNA Turn/Reposition Flow Record. 11/5/18 at approximately 3:30 PM - An interview with E7 (RN, UM) was conducted. E7 confirmed that the facility failed have evidence, that the interventions to limit sitting only for meals and side to side turning was implemented to promote healing of R95's PU. The facility failed to have a system, which	F 686	Committee meetings. If the audits indicate that we have maintained 100 percent compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice. Item 2b. Positioning R88 Individual/Resident Impacted The facility failed to ensure that R88 was positioned properly to promote healing and prevent risk of further pressure ulcers. Upon notification of this deficient practice, the Unit Manger met with all staff to review R88s care plan and turning schedule. Nursing staff was reminded of the importance of turning resident from side to side to prevent risk of further pressure ulcers. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice of not being positioned according to their turn schedule. Nursing Supervisors and Unit Managers received reminders by the Director of Nursing to conduct unit rounds to ensure that residents are on their proper turn schedule. System Changes The root cause of this deficient practice is failure of nursing staff to follow the person centered plan of care related to proper positioning to promote healing and prevent further pressure ulcers. Unit Managers, Nursing Supervisors or	

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F 686	Continued From page 58 ensured, the interventions to promote healing of R95's existing PU was implemented. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18. 2a. 6/17/10 - APIC standard of practice guidelines for wound care included: -When treating multiple ulcers on the same resident attend to the most contaminated ulcer last (eg. The perianal area. Review of R88's clinical record revealed: 3/17/15 - Admit to facility with diagnoses of bilateral (both sides) above the knee amputations (removal). 9/28/18 - MDS documented R88 as cognitively impaired, dependent assist of one for bed mobility, tube feeding, toileting (urinary incontinence and colostomy care), and bathing. 10/30/18 - Wound Evaluation Form revealed that R88 had a coccyx pressure ulcer, a right ischium pressure ulcer, and an open abscess to R88's left leg stump. 11/02/18 10:27 AM - Observation of wound care treatment with E22 (LPN) and E21 (CNA) assisting: Surveyor observed three open wounds: a coccyx, a right ischium, and left stump wounds. E22 (LPN) was observed cleansing and dressing R88's most contaminated (coccyx wound), go to the right ischium to dress, and then to the least contaminated (left stump open abscess) with the same pair of gloves.	F 686	Designee will make rounds every two hours to ensure compliance with residents turn schedule. Success Evaluation The Nursing Supervisor, Unit Manager, or designee will complete weekly audits of 100 percent of residents on a turning and repositioning schedule for (8) consecutive weeks to promote healing and prevent further pressure ulcers. If we have not achieved 100 percent compliance, the Director of Nursing (DON) or designee will determine the need for additional education related to the prevention and healing of pressure ulcers. The Continuous Quality Assurance Nurse (CQI RN III) will then audit 25% of all residents on turning and repositioning schedules to ensure compliance with their individualized turn schedules. The results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have achieved and maintained 100 % compliance for (3) consecutive months, the facility will conclude that we have successfully addressed this deficient practice.	

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F 686	Continued From page 59 11/2/18 1:20 PM - Interview with E21 (CNA) who confirmed that E22 (LPN) did not change her gloves during the treatment of R88's three wounds. (CNA) also confirmed that LPN started the three treatments with the coccyx wound. The facility failed to utilize a wound care technique to prevent the risk of infection. b. 12/15/17 (Updated 10/9/18) Impairment of skin care plan included: -Use pillow for positioning. -Turn and reposition every two hours left side to right side. -Do not position directly on pressure ulcer. 9/28/18 - MDS documented R88 as cognitively impaired, dependent assist of one for bed mobility, tube feeding, toileting (urinary incontinence and colostomy care), and bathing and was at risk for pressure ulcers. The following dates and times are observations of R88 lying in bed on his back and coccyx pressure ulcer: 10/31/18 - 09:28 AM; 10:19 AM 11/1/18 - 10:07 AM; 11:16 AM; 12:53 PM 11/2/18 - 8:50 AM 11/5/18 - 9:55 AM 11/1/18 2:30 PM - Interview with E21 (CNA) who confirmed that R88 allows staff to turn and reposition in bed. The facility failed to provide side to side turning to promote healing and prevent risk of further pressure ulcers.	F 686		

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F 697	Continued From page 60	F 697		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R110) out of 53 sampled residents. The facility failed to assess pain and provide intervention as indicated on 5 occasions. Findings include: The following was reviewed in R110's clinical record: 10/29/18 at 2:08 PM - Interveiw with R110 revealed that R110 has pain in the left foot and left leg. "They give me a pain medicine when it gets bad and I start yelling. If they give me the strong type of medication, it works. Sometimes they just give my (sic) Tylenol and it just dulls it." October 2018 - Activities of Daily Living flow sheet documented R110 having pain on October 1 for night, day and evening shift, October 2nd for night and evening shift, and October 3rd for night, day and evening shift. There was no evidence that an assessment by nursing or that pain medication was administered to R110 on October 1st, 2nd, or 3rd. The following was in the nursing notes in reference to R101's pain:	F 697	Individual/Resident Impacted The facility failed to follow professional standard of practice related to pain management. R110 complained of pain, however, there were no documented evidence that R110 complaint of pain was addressed by nursing staff. Upon notification of this deficient practice, the Unit Manager immediately met with nursing staff to remind them of the importance of pain assessment and timely addressing resident complaint of pain. All Nursing staff will receive a refresher in-service regarding the Pain Management Policy and the standard of practice related to pain management by the Director of Nursing / Trainer Educator III. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice of not adequately assessing pain and providing interventions for each resident with complaint of pain. A chart review of all residents CNA documentation and Pain Medication Administration Record were	1/3/19

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F 697	Continued From page 61 10/1/18 at 4:30 AM - "Foley Cath patent intact draining clear yellow urine no complaint of pain or discomfort" 10/2/18 at 5:45 AM - "Foley Cath intact patent draining yellow urine with some sediment no complaint of pain discomfort noted." 10/3/18 at 3:25 AM - "Foley Cath patent intact draining clear yellow urine no complaint of pain or discomfort." During an interview with E23 (CNA) on 11/05/18 at 11:06 AM, it was revealed that the CNA asks the resident when they receive care if they are having pain. If they are having pain the CNA will report to the nurse. The nurse follows up with the resident. Furthermore, it was revealed that at shift report there is opportunity to pass on information about the resident and if they are having pain. 11/5/18 11:06 AM -During an interview with E23 (CNA) it was revealed that they ask during care and they report to the nurse and the second opportunity happens during shift report. 11/5/18 11:26 AM During an Interview with E3 (ADON) requesting information on October 1, 2, and 3rd. 11/5/18 12:03 PM - E1 (NHA) provided nursing notes for 10/1, 10/2, 10/3. There is one note for each day that references the Foley catheter assessment and it included that R110 did not have a complaint of pain. It was confirmed that the foley catheter documentation was a daily note. There was no evidence that pain was assessed by nursing staff for the remaining 5 occasions. Findings reviewed with E1 (NHA), E2 (DON), and	F 697	completed to ensure that residents complaints of pain were assessed and appropriate interventions implemented 12/07/18. System Changes The root cause of this deficient practice is failure of nursing staff to follow professional standard of practice related to pain management, and the failure of CNA staff to report residents complaints of pain to a licensed staff for further assessment and intervention to address residentspain. All Nursing Staff will be in serviced by the Director of Nursing (DON) and Trainer educator III or designees regarding appropriate communication of residents complaints of pain using the Stop and Watch Form (Attachment 19). Additionally, all Nursing staff will receive a refresher in-service regarding the Pain management policy and the standard of practice related to pain management. The Unit Managers or their staff designees will complete a thorough review of CNA documentation and Pain Medication Administration Record before the end of each shift to ensure compliance. Failure to adhere to the Pain Management Policy or the standard of practice related to pain management will be reported to the Director of Nursing / Assistant Director of Nursing for appropriate actions. Success Evaluation The Unit Manager or designee will review all residents CNA documentation related to pain before the end of each shift. For all residents with complaints of pain, the Pain	

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F 697	Continued From page 62 E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 697	Medication Administration Record (MAR) and nurses notes will be reviewed for (8) consecutive weeks to ensure that all complaints of pain were reported, assessed, and appropriate interventions were provided to those residents. If we have not achieved 100 percent compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to pain management. The Continuous Quality Improvement Nurse (CQI RN III) will then conduct audits for 25% of 1) the CNA documentation related to pain, 2) Pain Medication Administration Records, and 3) nurse s notes if pain was indicated for (3) months to ensure sustainability. The results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have maintained 100 percent compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by:	F 808		1/3/19

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F 808	Continued From page 63 Based on observation, interview, and record review, it was determined that for 1 (R77) out of 53 sampled residents the facility failed to ensure liquids were served thickened as ordered by the physician. Findings include: 10/2018 - The monthly physician's order documented R77 was ordered, honey thickened liquids due to swallowing difficulty. 10/29/18 at 12:40 PM - During meal observation, E12 (CNA), opened a single serve packet of nectar thickener and proceeded to mix approximately half of the contents into R77's Italian Wedding soup. 10/29/18 at approximately 12:42 PM - An interview with E8 (Food Service Supervisor), revealed the consistency of R77's soup was like broth and R77 was served 4 ounces. E8 indicated that the staff would need to thicken the soup, by mixing in the prescribed thickener. 10/29/18 at approximately 12:45 PM - An interview with E12 (CNA) revealed that she was given the thickener by another aide, E18 (CNA). 10/29/18 at approximately 12:47 PM - An interview with E7 (RN, UM) confirmed R77 was ordered honey thickened liquid and not nectar consistency. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 808	Individual/Resident Impacted The facility failed to ensure that liquids for R77 were thickened as ordered by the physician. Immediately after notification of this deficient practice the Unit Manager reviewed the process of using the prescribed thickener with the staff responsible for R77s care. The unit manager completed a comprehensive assessment to ensure R77 had no signs and symptoms of aspiration. Identification of other residents with the potential to be affected All residents who are prescribed thickened liquids for swallowing difficulty have the potential to be affected by this deficient practice of not following the physician orders. The Unit Managers on each unit met with their staff to review the guidelines for using the thickeners as prescribed on 12/7/18. System Changes The root cause for this deficient practice is a knowledge deficit on the process of thickening liquids according to the physicians orders. All staff will be in serviced on using the prescribed consistency of liquids by the Registered Dietitian/Trainer Educator III or designee by January 03, 2018. This process will also be reviewed annually as part of CNA competency review. Success Evaluation The Registered Dietitian or designee will complete weekly flow tests of 50 percent of all thickened liquids ordered by the	

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F 808	Continued From page 64	F 808	physician for (8) consecutive weeks to ensure the consistency is correct. If we have not achieved 100 percent compliance, the Registered Dietician or designee will determine the need for additional training related to the proper consistency of thickened liquids. The Registered Dietician or designee will then conduct monthly audits for 50 percent of all residents who receive thickened liquids to ensure sustainability. The results of these audits will be reported at the monthly QAPI committee meetings. If the audits indicate that we have maintained 100 percent compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		1/3/19

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F 880	Continued From page 65 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 66 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R 88) out of 53 sampled residents the facility failed to perform necessary hand hygiene prior to providing wound care treatment. Additionally it was determined that the facility failed to conduct TB (Tuberculosis, lung disease) testing (PPD) for 1 out of 5 sampled residents. Findings included: 11/02/18 10:27 AM - Observation of pressure ulcer care with E22 (LPN) and E21 (CNA) assisting with positioning for the treatment. Dressing supplies were on the foot of R 88's bed. E22 donned a clean pair of gloves. E22 began to get set up for providing the dressing change. E22 reported that she had forgot the packing for the wound. E22 removed gloves and went to treatment cart for supply contaminating E22's hands. E22 did not wash her hands before donning clean gloves and performing the treatment. 11/2/18 1:20 PM - Interview with E21(CNA) who reported that she did not see (LPN) perform hand hygiene after retrieving supplies and prior to donning clean gloves to perform wound treatment. The facility failed to prevent risk of wound	F 880	Item 1 Hand Hygiene R88 Individual/Resident Impacted The facility failed to perform hand hygiene prior to providing wound care treatment to R88. The nurse contaminated her hands when she removed gloves and went to obtain additional supplies, and then forgot to wash her hands prior to donning clean gloves. The Infection Control Preventionist (ICP) reviewed the Hand Hygiene Policy with E22 on 12/03/18. E22 was reminded about the importance of proper hand hygiene by washing hands prior to donning clean gloves to prevent the risk of wound infection. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice. Residents are at risk for infection if proper hand hygiene procedures are not followed. All staff will receive a refresher in-service by the ICP Nurse and Trainer Educator III, regarding proper hand hygiene. Additionally, all licensed staff will be in-serviced regarding the appropriate practice of washing hands before donning gloves by the ICP Nurse and Trainer	

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F 880	Continued From page 67 infection by failing to perform hand hygiene prior to a procedure. 2. Review of facility records, interview, and review of the facility's policy and procedure, it was determined that the facility failed to conduct TB testing (PPD) for 1 out of 5 sampled residents. Policy and procedure titled, Tuberculosis Protocol, indicated, that the standard, was that all newly admitted residents to the facility will receive a two step PPD. Review of R57 clinical records revealed: 3/26/18 - Admitted to the facility. 3/26/18 - 1st step PPD administered. 3/28/18 - 1st step PPD results read and was documented as negative. Record review lacked evidence of administration of the 2nd step PPD. 11/5/18 at approximately 11:15 AM - An interview with E7 (RN, UM) confirmed the facility failed to adminster the 2nd step PPD. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), at approximately 4:42 PM on 11/5/18.	F 880	Educator III by January 03, 2019. System Changes The root cause of this deficient practice is the failure of nursing staff to follow professional standards of practice regarding hand hygiene and donning gloves, and failure to follow the Infection control policy specific to performing hand hygiene prior to donning gloves. The ICP Nurse and Trainer Educator III will provide a refresher in-service on proper hand hygiene to include washing hands prior to donning gloves. The ICP Nurse, Nursing Supervisors, or designee will conduct weekly audits (Attachment 20) during wound treatments to ensure that the necessary hand hygiene steps are being performed prior to initiating wound treatment. Additionally, visual reminders have been placed on all nursing units and bathrooms to remind staff to perform hand hygiene to prevent the spread of infections. Success Evaluation The Infection Control Preventionist (ICP), Nursing Supervisor or designee will complete a total of (20) weekly audits for (8) consecutive weeks to ensure that the hand hygiene protocol was followed. If we have not achieved 100 percent compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to the proper hand hygiene protocol. The Infection Control Preventionist (ICP), Nursing Supervisor, or designee will then conduct a total of (40) monthly audits for	

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F 880	Continued From page 68	F 880	(3) months to ensure sustainability. The results of these audits will be reported at the monthly QAPI committee meetings. If the audits indicate that we have maintained 100 percent compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice. Item 2 TB Testing R57 Individual/Resident Impacted The facility failed to conduct TB (Tuberculosis) testing (PPD) for resident R57. Record review did not document evidence of administration of the 2nd step PPD. The Unit Manager initiated a repeat tuberculin test (PPD) for R57. 1st step PPD administered on November 8, 2018 and 2nd step TB test (PPD) administered on November 13, 2018. Both PPD readings were negative. Identification of other residents with the potential to be affected All residents have the potential to be affected by this deficient practice of not administering TB (Tuberculosis) testing upon admission. A review of all residents charts were conducted to ensure that no other residents were affected as a result of this deficient practice. This chart review showed no other missing PPD tests for any resident. All licensed nursing staff will be reminded of the two-step PPD requirement for all residents upon admission. System Changes The root cause of the deficient practice is the failure of nursing staff to follow	

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F 880	Continued From page 69	F 880	professional standards of care related to TB testing and the infection control protocol. The Infection Control Preventionist (ICP) and Trainer / Educator III will provide a refresher in-service on the infection control policy specific to TB testing for all new admissions by January 03, 2019. In addition, a new Resident Immunization Tracking Tool (Attachment 21) has been created to include the two-step Tuberculin (PPD) skin test. This new tool will be completed by the ICP Nurse or designee and updated with new admissions. Success Evaluation The Infection Control Preventionist (ICP) or designee will conduct a chart review of all new admissions for (8) consecutive weeks to ensure that no PPD testing was omitted. If we have not achieved 100 percent compliance, the Director of Nursing (DON) or designee will determine the need for additional training related to the two-step PPD procedure. The Continuous Quality Improvement Nurse (CQI RN III) or designee will then complete a monthly audit of the immunization records of all newly admitted residents for (3) months to ensure sustainability. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If the audits indicate we have maintained compliance for (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice.	

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital F/t Chronically Ill (dhci) **DATE SURVEY COMPLETED: November 5, 2018**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from October 29, 2018 through November 5, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115. The survey sample totaled 53.		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L survey completed November 5, 2018: F565, F574, F577, F582, F584, F585, F622, F623, F641, F656, F657, F686, F697, F808, and F880.	Cross referenced CMS 2567-L survey completed November 5, 2018: F565, F574, F577, F582, F584, F585, F622, F623, F641, F656, F657, F686, F697, F808, and F880.	

NHA - 12/10/18

Provider's Signature **Barnabas M. Kerkula, NHA** Title **NHA** Date 12/10/2018